Suicide, Homelessness, Risk Assessment and Safety Planning

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Disclosure Statement

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Synopsis of Presentation

- Veterans, Homelessness & Suicide - A National Concern
- Suicide Risk Assessment – Speaking the Unspoken
- Safety Planning – Empowering Providers and Veterans
- Questions and Comments

Veterans, Homelessness & Suicide

Facts about Veteran Suicide

- Suicide rate (per 100,000)
  - Veterans utilizing VHA care → **35.9** (FY2009; Kemp & Bossarte, 2012)
  - General US population → 13.68 (2009; CDC, 2012)

- An estimated 20 Veterans die by suicide each day (Kemp & Bossarte, 2012)

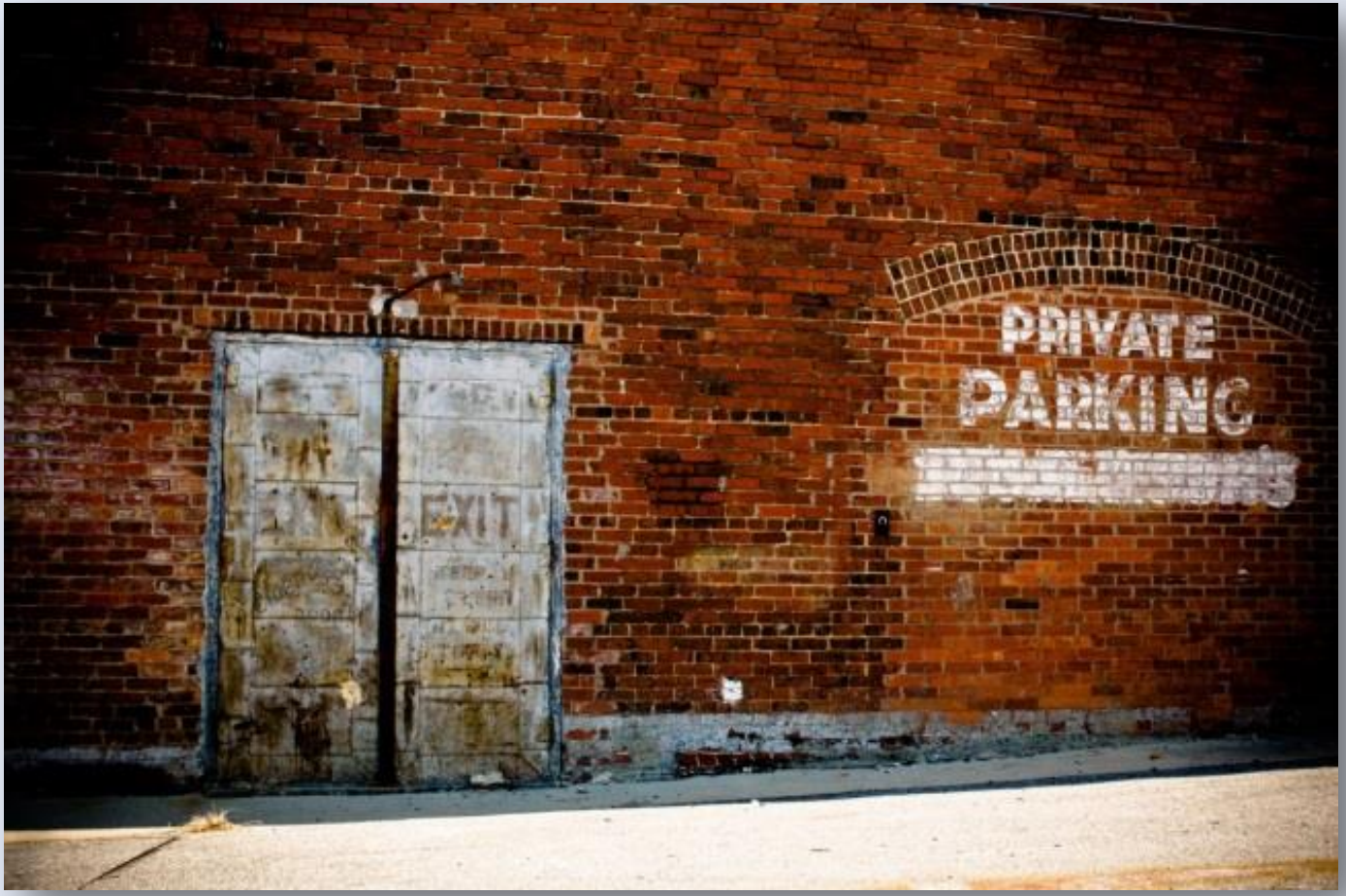
- Approximately 5 deaths per day among Veterans receiving care in VHA (SMITREC)

Homelessness

- Pervasive hardship
  - Economic
  - Social
  - Physical
- Considerable stigma

(Appio, Chambers, & Mao, 2013, Cozzarelli, Wilkinson, & Tagler, 2001)

Homelessness and Suicide



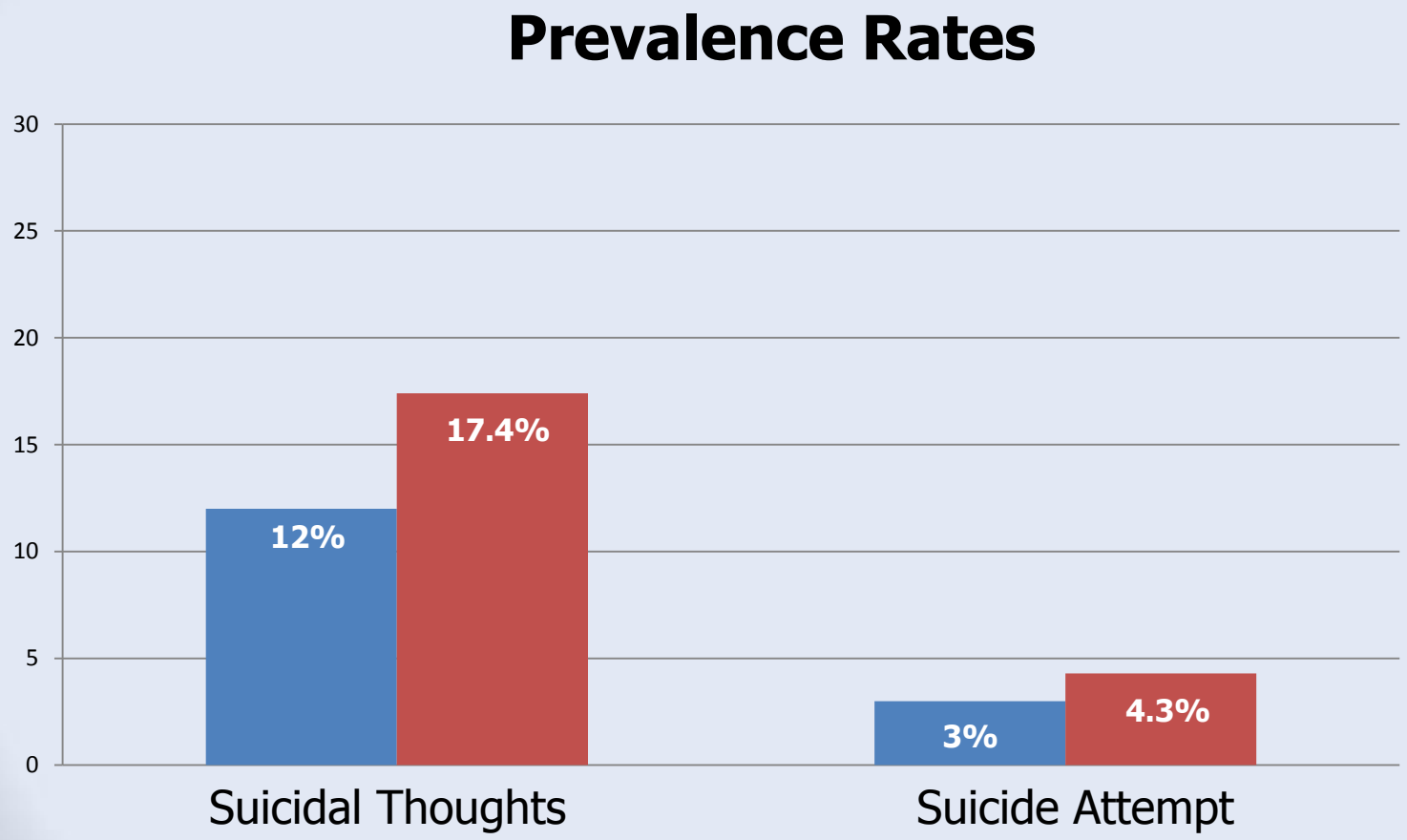
(Nordentoft & Wandall-Holm, 2003, Hwang et al., 2009, Eynan, et al, 2002)

Veterans and Homelessness

- Overrepresented among the homeless
- Currently 12-13% of adults

(Fargo et al., 201, Gamache et al., 2001; VA National Center on Homelessness among Veterans, 2011; Cortes, Henry, de la Cruz, & Brown; 2012)

Homeless Veterans



(Schinka, Schinka, Casey, Kasprow, & Bossarte, 2012; Goldstein, et al, 2008)

Homeless Veterans with Mental Illness

Prevalence Rates

Lifetime Ideation	Recent Ideation	Lifetime Attempt	Recent Attempt
66.2%	37.5%	51.33% (26.9%)	8.0%

(Desai, et al, 2003)

Homeless Veterans

- Predictors: Subjective report of one's state:
  - Serious depression
  - Difficulty controlling violent/aggressive behavior
- Protective Factors: Ethnicity
- Age Group Differences

(Goldstein et al., 2012; Schinka et al., 2012)

Gaps in the Research

Suicide Risk Assessment

Why Assess Risk?

- Inform treatment planning and interventions
- Purpose: to identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon 2001)
- Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)

Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

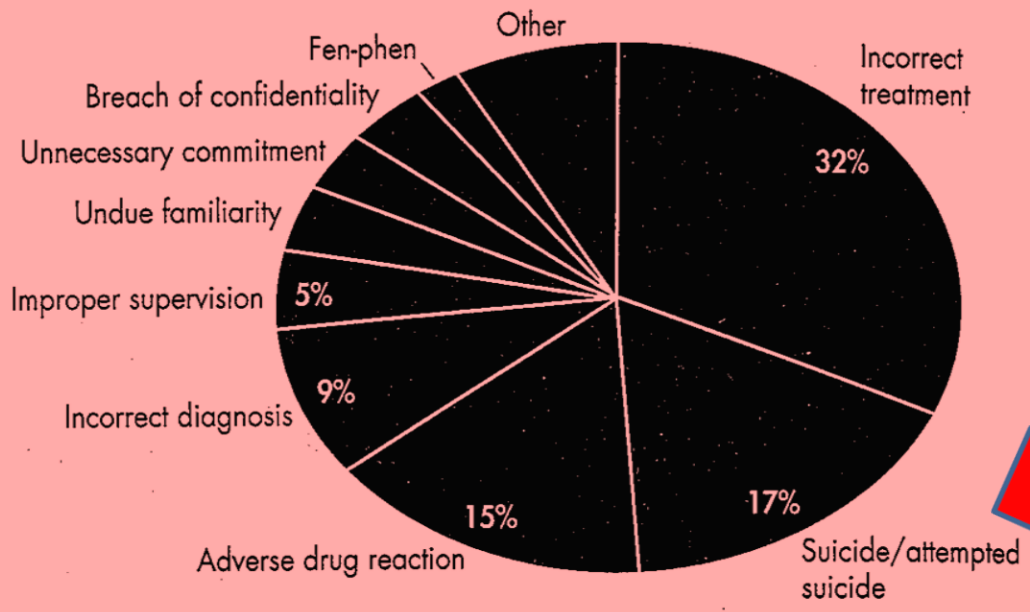


FIGURE 28–1. Most common malpractice claims against psychiatrists: United States, 1999–2003.

Source. The Psychiatrist's Program, the APA-Endorsed Psychiatrists' Liability Insurance Program, 2004.

Suicide Risk Assessment

- Suicide is a rare event
- No standard of care for the prediction of suicide
- Structured suicide measures augment but do not replace systematic risk assessment

Suicide Risk Assessment

Good clinical care = best risk management = minimum liability

- Suicide Risk Assessment
  - Clinical judgment of risk in the near future
  - Weighs available clinical detail

- Clinically Based Risk Management
  - Patient centered
  - Supports treatment process and therapeutic alliance

Simon 2006

Suicide Risk Assessment

- Standard of care: Conduct suicide risk assessment whenever indicated
- Attend to both risk and protective factors
- Risk assessment: Should be a process not an event
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

Suicide Risk Assessment

- Components:
  - Psychiatric Illness
  - History
  - Psychosocial situation
  - Individual strengths and vulnerabilities
  - Current presentation of suicidality
    - Specifically inquire about suicidal thoughts, plans, behaviors, and intent

Suicide Risk Assessment

- Psychiatric Illness:
  - Signs and Symptoms: Aggression, violence, impulsivity, insomnia, hopelessness?

- History:
  - Past suicidal or self-injurious behavior?
  - Document details: precipitant, timing, intent, consequences, and medical severity
  - Past treatment history and experiences?
  - Family history of suicide or mental illness?

Suicide Risk Assessment

- Individual Strengths and Vulnerabilities:
  - Coping skills, personality traits, thinking style, supportive relationships?

- Current Presentation: situation or crisis
  - Current situation or crisis?
  - Financial, legal, interpersonal conflict or loss, housing, employment issues?

Suicide Risk Assessment

- Current Suicidal ideation
  - Nature, frequency, intensity, extent of ideation?
- Current Suicide Plan
  - Presence or absence of a plan/method?
  - Any steps taken to enact or prepare plan?
  - What circumstances might lead to enacting plan?
  - GUNS?
- Current Suicide Intent
  - Intent to act on plan?
  - Lethality of plan?
  - Access to means?

Suicide Risk Assessment

- To estimate suicide risk, combine all elements:
  - Psychiatric illness
  - Medical illness
  - Acute stressors
  - Risk factors and patient-specific warning signs
  - Protective factors
  - Nature, intensity, frequency of suicidal thoughts, plans, and behaviors

Risk Factors and Warning Signs

Suicide Risk Factors

- Factors associated with increased risk
- A major focus of research for past 30 years
- Categories of risk factors
  - Demographic
  - Psychiatric
  - Psychosocial stressors
  - Past history

Suicide Warning Signs

- Person-specific emotions, thoughts, or behaviors precipitating suicidal behavior
- Proximal to the suicidal behavior and imply imminent risk
- Dangerous combination: presence of suicide warning signs with suicide risk factors

Risk Factors vs. Warning Signs

Characteristic Feature	Risk Factor	Warning Sign
Relationship to Suicide	Distal	Proximal
Empirical Support	Evidence-base	Clinically derived
Timeframe	Enduring	Imminent
Nature of Occurrence	Relatively stable	Transient
Implications for Clinical Practice	At times limited	Demands intervention

Risk Factors vs. Warning Signs

Risk Factors	Warning Signs
•Suicidal ideas/behaviors •Psychiatric diagnoses •Physical illness •Childhood trauma •Genetic/family effects •Psychological features (i.e. hopelessness) •Cognitive features •Demographic features •Access to means •Substance intoxication •Poor therapeutic relationship	•Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself • Seeking access to lethal means •Talking or writing about death, dying or suicide •Increased substance (alcohol or drug) use •No reason for living; no sense of purpose in life •Feeling trapped - like there's no way out •Anxiety, agitation, unable to sleep • Hopelessness •Withdrawal, isolation

Modifiable Risk Factors?

Non-modifiable Risk Factors

- Family History
- Past history
- Demographics

Modifiable Risk Factors

- Treat psychiatric symptoms
- Increase social support
- Remove access to lethal means

Modifiable Protective Factors?

- Key to addressing long-term or chronic risk
  - Sense of responsibility to family
  - Reality testing ability
  - Positive coping skills
  - Positive problem-solving skills
  - Enhanced social support
  - Positive therapeutic relationships

Acute v. Chronic Risk

A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

Acute v. Chronic Risk

- Acute and chronic risk are dissociable

- Document estimation for each

  "Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior."

Psychiatric Management

- Establish/Maintain therapeutic alliance
  - Taking responsibility for patient's care is not the same as taking responsibility for the patient's life
- Attend to safety and determine treatment setting
  - Level of observation, frequency of sessions
  - Restricting access to means
  - Consider safety needs, optimal treatment setting, and patient's ability to benefit from such

Develop a Treatment Plan

- Particular attention should be paid to modifiable risk and protective factors

- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc.

Safety Planning: A Stand Alone Intervention

No-Suicide Contracts

- What are they?
  - Typically entails a patient agreeing to not harm themselves
  - Sometimes includes what to do if they can no longer abide by the contract

- Up to 79% of mental health professionals report using them *despite there being no empirical support regarding their effectiveness* (Drew, 1999; Rudd et al., 2006)

No-Suicide Contracts
Reasons to Not Use Them

- Medicolegal
  - Not legally binding; no protection against malpractice (Stanford et al., 1994; Simon, 1999)
  - Erroneous to believe it can prevent suicide (Simon, 1999)
- Provider-specific
  - False sense of security (Simon, 1999)
  - Absence of therapeutic relationship (Simon, 1999)
- Patient-centered
  - Concern that provider only worried about legal protection (Range et al., 2002)
  - Could discourage open disclosure of thoughts, plan, etc. (Range et al., 2002)

What is Safety Planning?

- A brief clinical intervention
- Follows risk assessment
- A hierarchical and prioritized list of coping strategies and sources of support
- To be used during or preceding a suicidal crisis
- Involves collaboration between the patient and clinician

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* Retrieved from http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Tips for Developing a Safety Plan

- Ways to increase collaboration
  - Sit side-by-side
  - Use a paper form
  - Allow the patient to write
- Brief instructions using the patient's own words
- Easy to read
- Address barriers and use a problem-solving approach

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* Retrieved from http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf

6 Steps of Safety Planning

- Step 1: Recognizing Warning Signs
- Step 2: Using Internal Coping Strategies
- Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support
- Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve the Crisis
- Step 5: Contacting Professionals and Agencies
- Step 6: Reducing the Potential for Use of Lethal Means

Step 1: Recognize Warning Signs

- Purpose: To help the patient identify and pay attention to his or her warning signs
- Personal situations, thoughts, images, thinking styles, mood or behavior
- “How will you know when the safety plan should be used?”
- Specific and personalized examples

Step 2: Using Internal Coping Strategies

- Purpose: To take the patient's mind off of problems to prevent escalation of suicidal thoughts
  - **NOT** to solve the patient's problems
- List activities the patient can do without contacting another person
- This step helps patients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time

Step 3: People and Social Settings that Provide Distraction

- Purpose: To engage with people and social settings that will provide distraction
- Also increases social connection
- The client is not telling someone they are in distress during this step
- Avoid listing any controversial relationships

Step 4: Contacting Family Members or Friends Who May Offer Help

- Purpose: To explicitly tell a family member or friend that he or she is in crisis and needs support
- Can be the same people as Step 3, but different purpose
- If possible, include a family member or friend in the process by sharing the safety plan with them

Step 5: Contacting Professionals and Agencies

- Purpose: The client should contact a professional if the previous steps do not work to resolve the crisis

- Include name, phone number and location
  - Primary mental health provider
  - Other providers
  - Urgent care or emergency psychiatric services
  - National Crisis Hotline 800-273-TALK (8255)
  - 911

Step 6 : Reducing the Potential for Use of Lethal Means

- Complete this step even if the client has not identified a suicide plan
- Eliminate or limit access to any potential lethal means
- Always ask about access to firearms
- Discuss medications and how they are stored and managed
- Consider alcohol and drugs as a conduit to lethal means

Resources

VISN 19 MIRECC
http://www.mirecc.va.gov/visn19/

VA Safety Planning Manual
www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc

VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide

- Comprehensive
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more

http://prevention.mt.gov/suicideprevention/PCP-GuidelinesForSuicideAssessmentofVets.pdf

Thank you!

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